

COMPLAINT CASE NUMBER:

OMB NO.: 2900-0715  
EXPIRATION DATE: DEC 31, 2019  
RESPONDENT BURDEN: 30 Min.

Department of Veterans Affairs

**COMPLAINT OF EMPLOYMENT DISCRIMINATION***Read the instructions on the reverse side of this form carefully before completing the front of this form.*

1. NAME (Last, first, middle initial) (Please print) Friedman, Howard A		3. MAILING ADDRESS 5521 Harleston Drive Lyndhurst, Ohio 44124		4a. WORK TELEPHONE NUMBER (Include Area Code)	
2. EMAIL ADDRESS				4b. PRIMARY TELEPHONE NUMBER (Include Area Code) 216-201-0123	
5. ARE YOU: <input checked="" type="checkbox"/> A VA EMPLOYEE <input type="checkbox"/> AN APPLICANT FOR EMPLOYMENT <input type="checkbox"/> A FORMER VA EMPLOYEE		5a. JOB TITLE, SERIES AND GRADE Medical Manager/physician 5b. SERVICE/SECTION/PRODUCT LINE COPS		7. NAME AND ADDRESS OF VA FACILITY WHERE DISCRIMINATION OCCURRED 35000 Kaiser Court Willoughby, Oh 44094	
NOTE: For each employment related matter that you believe was discriminatory you must list the bases (list one or more of the following): Race (Specify), Color (Specify), Religion (Specify), Sex (Male or Female), National Origin (Specify), Age (Provide date of birth), Disability (Specify), Genetic Information (including family medical history), and/or Retaliation for participating in the EEO process or opposing unlawful discrimination.					
8. BASIS		9. CLAIM(S) (What employment related claim(s) - personnel action(s), incident(s), or event(s) caused you to file this complaint? Briefly state the specific claim, personnel action and/or event that caused you to file this complaint. Use an additional sheet of paper if necessary. You should not include information that violates the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA). Some examples are patient medical records, personal records of other VA employees, etc.)			10. DATE OF OCCURRENCE (Include the most recent date(s))
Age (01/1958)		Disciplinary Action (Suspension)			2-8-21
(Jewish)		Evaluation/Performance/Appraisal			2-1-21
		Pay and Allowances- (Special Pay)			12-24-20
		Lose of Credentials			3-4-21
11. REMEDIES SOUGHT (Use an additional sheet of paper if necessary.) Rescission of actions, compensatory damages.					
12a. DO YOU HAVE A REPRESENTATIVE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		12c. PROVIDE THE NAME AND ADDRESS OF YOUR REPRESENTATIVE Joshua Kahn		12d. TELEPHONE NUMBER (Include Area Code) 800-801-0598	
12b. IF "YES," IS HE OR SHE AN ATTORNEY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				12e. EMAIL ADDRESS josh@pinesfederal.com	
13a. HAVE YOU CONTACTED AN EEO COUNSELOR? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13b. NAME OF EEO COUNSELOR David B. Taylor		13c. DATE OF INITIAL CONTACT WITH ORM 2-22-21	
14. If you contacted an EEO Counselor more than 45 calendar days after the Date(s) of Occurrence, listed in Item 10, or if this complaint is filed more than 15 calendar days after receipt of a Notice of Right to File a Discrimination Complaint, you must explain why you were untimely in seeking EEO counseling or untimely in filing a complaint. (Use an additional sheet of paper, if necessary.)					
15a. HAVE YOU FILED A UNION GRIEVANCE ON ANY CLAIM(S) LISTED ABOVE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		15b. IF "YES," LIST THE CLAIM(S) AND DATE GRIEVANCE FILED NA		15c. HAVE YOU FILED AN APPEAL WITH THE MERIT SYSTEM PROTECTION BOARD (MSPB) ON ANY OF THE CLAIMS LISTED ABOVE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15d. IF "YES," LIST THE ISSUE(S) AND DATE MSPB APPEAL FILED. NA					
17a. HAVE YOU FILED THIS COMPLAINT WITH ANYONE ELSE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		17b. IF "YES," PROVIDE THE NAME AND ADDRESS			
18. SIGNATURE OF COMPLAINANT (Do not print) 				19. DATE 3-26-21	

VA FORM  
MAR 2017 **4939**SUPERSEDES VA FORM 4939, MAR 2013,  
WHICH SHOULD NOT BE USED.**GOVERNMENT  
EXHIBIT****B**